Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

RENAISSANCE HOSPITAL
C/O BURTON & HYDE PLLC
PO BOX 684749
AUSTIN TX 78768-4749

Carrier's Austin Representative Box
#01

MFDR Date Received
JANUARY 20, 2006

Respondent Name
LIBERTY INSURANCE CORP

MFDR Tracking Number
M4-06-3435-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary Taken From The Table of Disputed Services: "Carrier did not pay claim at TWCC stop loss. Carrier did make additional payment, however hospital is requesting we be reimbursed at TWCC stop loss."

Requestor's Supplemental Position Summary Dated January 3, 2011: "1. **The Audited charges for each of [Claimant]'s admissions exceeds the $40,000 stop-loss threshold**. The hospital billed $185,674.58 for the first admission. The carrier paid $73,915.05…The hospital billed $116,156.03 for the second admission. The carrier paid $12,007.06…2. **The services rendered to [Claimant] were unusually costly and extensive**…[Claimant's] admissions involve most unusual circumstances. The surgeons would have completed the procedures during his first hospitalization, but two events delayed the 360 degree L5-S1 fusion – he contracted a severe bacterial infection and during the attempts to control his prolonged fever his admission was interrupted by the evacuation of Renaissance Hospital – Houston on account of Hurricane Rita. As a result, the services rendered to [Claimant] were unusually costly and unusually extensive…:

- **Infection.** [Claimant's] extended stay of fourteen days during his first admission was the result of bacterial infection. The infection, enterococcus, is resistant to many antibiotics and associated with high mortality rate. He suffered a fever in excess of 100 degrees…Therefore, the surgeon delayed the second stage of the 360 degree L5-S1 fusion until [Claimant's] temperature was within a normal range. [Claimant's] fever did not subside before the unexpected evacuation of the hospital; therefore, the surgeries still to be completed were postponed until he could be readmitted.
- **Multiple surgeries.** [Claimant] underwent multiple procedures and required two hospital admissions to complete the 360 degree L5-S1 fusion. The second admission was required because not only did he suffer a bacterial infection during his first hospitalization, he also had to be evacuated on September 21, 2005 during Hurricane Rita. During his first admission, the following surgeries were performed: anterior discectomy, anterior and posterior osteotomy, insertion of orthopedic implant, anterior lumbar arthrodesis with InFUSE, and anterior instrumentation. When [Claimant] was readmitted to the hospital to complete the 360 degree fusion, the following surgeries were performed; right posterolateral fusion, left posterolateral fusion, bilateral pedical stabilization, bone graft, and fluoroscopic supervision and control.
- **Complications**. [Claimant] experienced complications. During surgery, he suffered some hemorrhaging. After surgery he had a high fever and abdominal pain.

- **Front-loaded costs**. The cost associated with the hospital's services in this case are front loaded. [Claimant's] underwent a complicated surgical procedure requiring an investment in skilled professionals and advanced facilities and medical equipment. Furthermore, the hospital spent $43,856 on implants for the first admission, of which the carrier only paid $13,020.70. The hospital incurred a cost of $35,362.50 for the implants used in the second admission, of which the carrier only paid $7,769.26…For these reasons, the Medical Fee Dispute Officer should find that the second-prong of the two part test is satisfied and order additional reimbursement be paid by the carrier according to the stop-loss calculation methodology."

Requestor's Supplemental Position Summary Dated March 5, 2013: "When compared to the results of a statistical survey of system-wide data maintained by the Division for hospital inpatient admissions in Texas, [Claimant's] total sixteen (16) day hospital stay was outside of the ordinary because it was longer than most others and exceeded system norms. The average length of stay for hospital inpatient admissions system-wide in the State of Texas for 2005 was four (4) days. The average length of stay for 2005 admissions with Principle Diagnosis Code 722.10 and Principle Procedure Code 81.06 was eight (8) days…Additionally, the hospital was required to close due to Hurricane Rita, which further complicated [Claimant's] admission, causing him to have to be readmitted later to finish all of his surgical procedures…[Claimant's] hospital admission was outside of the ordinary because the cost of the services for this admission when compared to the results of a statistical survey of system-wide data maintained by the Division for hospital inpatient admissions in Texas exceeded the norm. The average amount billed for hospital inpatient admissions system-wide in the State of Texas in 2005 was $29,863.42. The average amount billed for hospital inpatient admissions with Principal Diagnosis Code (722.10) and Principal Procedure Code (81.06) in 2005 was $99,975.85. The total charge for [Claimant's] surgical procedures was $301,830.615. [Claimant's] hospital admission was outside of the ordinary because the amount billed was greater than the system-wide average for 2005…The hospital incurred a great up-front cost associated with the hospital's services in this case. [Claimant's] underwent complicated surgical procedures requiring an investment of skilled professionals and advanced facilities and medical equipment…For these reasons…the admission was unusually costly and extensive…"

Amount in Dispute: $104,148.97

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary Dated February 10, 2006: "The bill and documentation attached to the medical dispute have been re-reviewed and our position remains the same…**Per the TWCC Medical Dispute Resolution Newsletter, in order for the provider to be reimbursed at the stop loss, the billed charges must not only exceed the $40,000.00 threshold but there must be something out of the ordinary (unusual for the hospital stay, such as complications, infections or multiple surgeries. We find no indication of the bill meeting this criteria; therefore; the provider was paid per the TX FS surgical per diem, ICU per diem plus carve outs rather than the stop loss reimbursement methodology**… Liberty Mutual does not believe that Renaissance Hospital is due any further reimbursement……"

Response Submitted by: Liberty Insurance Corp.

SUMMARY OF FINDINGS

Disputed Dates	Disputed Services	Amount In Dispute	Amount Due
October 7, 2005 through October 10, 2005	Inpatient Hospital Services	$104,148.97	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 and §133.307, 27 *Texas Register* 12282, applicable to requests filed on or after January 1, 2003, sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.401, 22 *Texas Register* 6264, effective August 1, 1997, sets out the fee guidelines for inpatient services rendered in an acute care hospital.

3. 28 Texas Administrative Code §134.1, 27 *Texas Register* 4047, effective May 16, 2002, sets out the guidelines for a fair and reasonable amount of reimbursement in the absence of a contract or an applicable division fee guideline.

The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of Benefits

- Z585 – The charges for this procedure exceeds fair and reasonable.
- W10-No maximum allowable defined by fee guideline. Reimbursement made based on insurance carrier fair and reasonable reimbursement methodology.
- Z695 – The charges for this hospitalization have been reduced based on the fee schedule allowance.
- W1-Workers Compensation state fee schedule adjustment.
- Z560 – The charge for this procedure exceeds the fee schedule or usual and customary allowance.
- Z989 – the amount paid previously was less than is due. The current recommended amount is the result of supplemental payment.

U.S. Bankruptcy Judge Michael Lynn issued a "STIPULATION AND ORDER GRANTING RELIEF FROM AUTOMATIC STAY TO PERMIT CONTINUANCE AND ADJUDICATION OF DISPUTED WORKERS COMPENSATION CLAIMS BEFORE THE TEXAS STATE OFFICE OF ADMINISTRATIVE HEARINGS," dated August 27, 2010, in the case of *In re: Renaissance Hospital – Grand Prairie, Inc. d/b/a/ Renaissance Hospital – Grand Prairie, et al.*, in the United States Bankruptcy Court for the Northern District of Texas, Fort Worth Division in Case No. 08-43775-7. The order lifted the automatic stay to allow continuance of the claim adjudication process as to the workers' compensation receivables before SOAH, effective October 1, 2010. The order specified John Dee Spicer as the Chapter 7 trustee of the debtor's estate. By letter dated October 5, 2010, Mr. Spicer provided express written authorization for Cass Burton of the law office of Burton & Hyde, PLLC, PO Box 684749, Austin, Texas 78768-4749, to be the point of contact on Mr. Spicer's behalf relating to matters between and among the debtors and the Division concerning medical fee disputes. The Division will utilize this address in all communications with the requestor regarding this medical fee dispute.

Issues

1. Did the audited charges exceed $40,000.00?
2. Did the admission in dispute involve unusually extensive services?
3. Did the admission in dispute involve unusually costly services?
4. Is the requestor entitled to additional reimbursement?

Findings

This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 Texas Administrative Code §134.401, titled *Acute Care Inpatient Hospital Fee Guideline*, effective August 1, 1997, 22 Texas Register 6264. The Third Court of Appeals' November 13, 2008 opinion in *Texas Mutual Insurance Company v. Vista Community Medical Center, LLP*, 275 *South Western Reporter Third* 538, 550 (Texas Appeals – Austin 2008, petition denied) addressed a challenge to the interpretation of 28 Texas Administrative Code §134.401. The Court concluded that "to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed $40,000 and that an admission involved unusually costly and unusually extensive services." Both the requestor and respondent in this case were notified via form letter that the mandate for the decision cited above was issued on January 19, 2011. Each was given the opportunity to supplement their original MDR submission, position or response as applicable. The division received supplemental information as noted in the position summaries above. The supplemental information was shared among the parties as appropriate. The documentation filed by the requestor and respondent to date will be considered in determining whether the admission in dispute is eligible for reimbursement under the stop-loss method of payment. Consistent with the Third Court of Appeals' November 13, 2008 opinion, the division will address whether the total audited charges ***in this case*** exceed $40,000; whether the admission and disputed services ***in this case*** are unusually extensive; and whether the admission and disputed services ***in this case*** are unusually costly. 28 Texas Administrative Code §134.401(c)(2)(C) states, in pertinent part, that "Independent reimbursement is allowed on a case-by-case basis if the particular case exceeds the stop-loss threshold as described in paragraph (6) of this subsection…" 28 Texas Administrative Code §134.401(c)(6) puts forth the requirements to meet the three factors that will be discussed.

1. 28 Texas Administrative Code §134.401(c)(6)(A)(i) states "…to be eligible for stop-loss payment the total

audited charges for a hospital admission must exceed $40,000, the minimum stop-loss threshold." Furthermore, (A) (v) of that same section states "…Audited charges are those charges which remain after a bill review by the insurance carrier has been performed…" Review of the explanation of benefits issued by the carrier finds that the carrier did not deduct any charges in accordance with §134.401(c)(6)(A)(v); therefore the audited charges equal $116,156.03. The Division concludes that the total audited charges exceed $40,000.

2. In its original position statement, the requestor asserts that "Carrier did not pay claim at TWCC stop loss. Carrier did make additional payment, however hospital is requesting we be reimbursed at TWCC stop loss." 28 Texas Administrative Code §134.401(c)(2)(C) allows for payment under the stop-loss exception on a case-by-case basis only if the particular case exceeds the stop-loss threshold as described in paragraph (6). Paragraph (6)(A)(ii) states that "This stop-loss threshold is established to ensure compensation for unusually extensive services required during an admission." The Third Court of Appeals' November 13, 2008 opinion states that "to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed $40,000 and that an admission involved unusually costly and unusually extensive services." The requestor's original position statement failed to discuss the particulars of the admission in dispute that may constitute unusually extensive services. In its supplemental position statement, the requestor considered the Courts' final judgment. In regards to whether the services were unusually extensive, the Third Court of Appeals' November 13, 2008 opinion concluded that in order to be eligible for reimbursement under the stop-loss exception, a hospital must demonstrate that an admission involved unusually extensive services. The requestor's supplemental position statement asserts, that the services rendered to [Claimant] were unusually costly and extensive because:

   - The evacuation of Renaissance Hospital – Houston on account of Hurricane Rita. The evacuation of the hospital occurred during the first admission, not the second admission the basis of this dispute.
   - Infection. The claimant's bacterial infection occurred during the first admission, not the second admission the basis of this dispute
   - Multiple surgeries.
   - Complications. The requestor noted in the position summary that "During surgery, he suffered some hemorrhaging. After surgery he had a high fever and abdominal pain." A review of the Discharge Summary for the second admission indicates "ON completion of that operation, the patient's clinical stay in the hospital has been unremarkable. Therefore, the complications listed are not supported.

   The requestor's position that this admission is unusually extensive due to the above listed reasons fails to meet the requirements of §134.401(c)(2)(C) because the requestor failed to demonstrate how the services in dispute were unusually extensive in relation to similar spinal surgeries or admissions.

   The division concludes that the requestor failed to meet the requirements of 28 Texas Administrative Code §134.401(c)(2)(C).

3. 28 Texas Administrative Code §134.401(c)(6) states that "Stop-loss is an independent reimbursement methodology established to ensure fair and reasonable compensation to the hospital for unusually costly services rendered during treatment to an injured worker." The requestor in its supplemental position summary states:

   > [Claimant's] hospital admission was outside of the ordinary because the cost of the services for this admission when compared to the results of a statistical survey of system-wide data maintained by the Division for hospital inpatient admissions in Texas exceeded the norm. The average amount billed for hospital inpatient admissions system-wide in the State of Texas in 2005 was $29,863.42. The average amount billed for hospital inpatient admissions with Principal Diagnosis Code (722.10) and Principal Procedure Code (81.06) in 2005 was $99,975.85. The total charge for [Claimant's] surgical procedures was $301,830.615. [Claimant's] hospital admission was outside of the ordinary because the amount billed was greater than the system-wide average for 2005.

   The division notes that the audited charges of $116,156.03 are discussed above as a separate and distinct factor pursuant to 28 Texas Administrative Code §134.401(c)(6)(A)(i). The requestor asserts that because the amount ***billed charges*** exceeds the average for the same principal diagnosis and procedure codes, the ***cost*** of the services is therefore "out of the ordinary." Although the requestor lists and quantifies ***billing*** data, the requestor fails to list or quantify the ***costs*** associated with the disputed services. In the adoption preamble to the Division's former *Acute Care Inpatient Hospital Fee Guideline*, 22 *Texas Register* 6276, the division concluded that "hospital charges are not a valid indicator of a hospital's costs of providing services."

   The requestor further states:

   > The hospital incurred a great up-front cost associated with the hospital's services in this case. [Claimant's] underwent complicated surgical procedures requiring an investment of skilled professionals and advanced facilities and medical equipment.

The requestor does not list or quantify the costs associated with these resources in relation to the disputed services, nor does the requestor provide documentation to support a reasonable comparison between the resources required for the spinal surgery. Therefore, the requestor fails to demonstrate that the resources used in this particular admission are unusually costly when compared to resources used in other types of surgeries.

The division concludes that the billed charges for the services do not represent the cost of providing those services. The requestor fails to demonstrate that the hospital's resources used in this particular admission are unusually costly.

4. For the reasons stated above the services in dispute are not eligible for the stop-loss method of reimbursement. Consequently, reimbursement shall be calculated pursuant to 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount* and §134.401(c)(4) titled *Additional Reimbursements.* The Division notes that additional reimbursements under §134.401(c)(4) apply only to bills that do not reach the stop-loss threshold described in subsection (c)(6) of this section.

- Division rule at 28 Texas Administrative Code §134.401(c)(3)(ii) states, in pertinent part, that "The applicable Workers' Compensation Standard Per Diem Amount (SPDA) is multiplied by the length of stay (LOS) for admission…" Review of the submitted documentation finds that the length of stay for this admission was one surgical days and two ICU/CCU; therefore the standard per diem amounts of $1,118.00 and $1,560.00 apply respectively. The per diem rates multiplied by the allowable days result in a total allowable amount of $4,238.00.
- 28 Texas Administrative Code §134.401(c)(4)(A), states "When medically necessary the following services indicated by revenue codes shall be reimbursed at cost to the hospital plus 10%: (i) Implantables (revenue codes 275, 276, and 278), and (ii) Orthotics and prosthetics (revenue code 274)."
- A review of the submitted medical bill indicates that the requestor billed revenue code 278 for Implants at $58,472.00.
- Review of the medical documentation provided finds that although the requestor billed items under revenue code 278, no invoices were found to support the cost of the implantables billed. For that reason, no additional reimbursement can be recommended.
- 28 Texas Administrative Code §134.401(c)(4)(B) allows that "When medically necessary the following services indicated by revenue codes shall be reimbursed at a fair and reasonable rate: (iv) Blood (revenue codes 380-399)." A review of the submitted hospital bill finds that the requestor billed $1,042.16 for revenue code 382-Blood/Whole; $900.00 for revenue code 386-Blood/Components; and $3,561.96 for revenue code 390-Blood/Storage/Processing. 28 Texas Administrative Code §133.307(g)(3)(D), requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that the requestor does not demonstrate or justify that the amount sought for revenue codes 382, 386 and 390 would be a fair and reasonable rate of reimbursement. Additional payment cannot be recommended.
- 28 Texas Administrative Code §134.401(c)(4)(C) states "Pharmaceuticals administered during the admission and greater than $250 charged per dose shall be reimbursed at cost to the hospital plus 10%. Dose is the amount of a drug or other substance to be administered at one time." A review of the submitted itemized statement finds that the requestor billed $306.00/unit for Thrombinar 5000 units. The requestor did not submit documentation to support what the cost to the hospital was for these items billed under revenue code 250. For that reason, additional reimbursement for these items cannot be recommended.

The division concludes that the total allowable for this admission is $4,238.00. The respondent paid $12,007.06. Based upon the documentation submitted, no additional reimbursement can be recommended.

Conclusion

The submitted documentation does not support the reimbursement amount sought by the requestor. The requestor in this case demonstrated that the audited charges exceed $40,000, but failed to demonstrate that the disputed inpatient hospital admission involved unusually extensive services, and failed to demonstrate that the services in dispute were unusually costly. Consequently, 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount,* and §134.401(c)(4) titled *Additional Reimbursements* are applied and result in no additional reimbursement.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		04/12/2013
Signature	Medical Fee Dispute Resolution Officer	Date
		04/12/2013
Signature	Health Care Business Management Director	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.
Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.